who has not had some military experience, and that it is, therefore, not to be wondered at that the younger men are anxious to serve in foreign armies when Germany is at peace. Hence he readily gave permission to his assistant to spend a few months in testing the antiseptic method of dressing, and the other new resources of surgery, on the field of battle and in the military hospitals.

The author seems to have used Lister's method quite extensively, though at times it must have been difficult to have obtained the necessary paraphernalia. He speaks on page 148 of an interesting case in which he tied the brachial artery for hemorrhage accompanying gunshot fracture of the forearm. Bleeding continued though he was sure the artery was ligated, and he accordingly searched for a second brachial, on the supposition that a high bifurcation was present in the case operated on; this he found and tied, when hemorrhage ceased and the case progressed favourably. The frequent occurrence of osteitis after operations is mentioned. This, he says, might perhaps be attributed to the dull saws likely to be employed in military surgery; but the rapid transportation of the wounded, which was required, is to his mind a sufficient cause to be at least one factor in the production of this complication (pp. 144–145). The illustrations, of which there are altogether nine, show specimens of explosive bullets and gunshot injuries of bones and viscera.

The book, for one that does not pretend to be entirely scientific, contains considerable material of interest to professional readers.

J. B. R.

ART. XXXI.—*Transactions of the American Ophthalmological Society.* Fifteenth Annual Meeting. 8vo. pp. 105. New York, 1879.

THE first paper is by Dr. Knapp, of New York, *On the Operation of some kinds of Complicated Cataract.* The kinds of cataract referred to are: hypermature cataract with thickened capsule, and cataract complicated with fluidity of the vitreous. In the former kind, after the usual corneal section, and iridectomy, Dr. Knapp makes a large peripheric opening of the capsule. When the thickened capsule requires a secondary operation, he makes a horizontal incision through it along the upper border of the thick part, then a vertical one above the horizontal and joining the latter in the centre, and then couches the lower thickened portion behind the iris.

In the second kind of cataract, that complicated with fluid vitreous, the corneal incision is made less peripheric than usual, and if vitreous escapes no iridectomy is made. The author thinks that the iris, left in position, will, to a certain extent, supply the protection which the vitreous receives from the suspensory ligament, when the latter is not defective.

In a paper on the *Influence, on the Refraction, of four years of College Life,* Dr. HASKET DERBY, of Boston, gives the result of two examinations of the eyes of the class of 1879, at Amherst. All the members of the class were examined on entering college, and again at the end of the course. The percentage of myopia found at the first examination was 44, and at the last 50. Myopia was developed from previous emmetropia in 10.6 per cent. of the class, increased in amount in 21.2 per cent., and remained unchanged in 16.6 per cent.

The number of the class, 83, is too small for the results of the examinations to be at all conclusive, but they are at least suggestive and valuable as far as they go. Dr. Derby proposes to follow at least four successive classes through their college course, and promises to make a more extended report three years hence.

The author says very truly that—

> "The commonly accepted statement that the greatest and most important changes in refraction are apt to take place between the 5th and 20th year, is fully supported by facts, as far as they go. But most investigations have stopped at this age. The changes that may take place after 20, and the rate at which they go on during the subsequent years of educational life, have never, as yet, been made to any extent the subject of accurate inquiry."

Dr. J. KIPP, of Newark, N. J., contributed a short paper on *Dacryocystitis in Nursing Infants.* This disease is usually considered to be extremely rare in very young children, but Dr. Kipp finds that ten per cent. of the cases occurring in his practice in the last two years were in patients under one year of age. In nearly all these cases it was associated with nasal catarrh, and in none of the cases in which he had an opportunity to probe, could a stricture be felt. The following is his plan of treatment:—

> "Unless the sac can be easily emptied by slight pressure, the lower canaliculus is slit. After that the nurse is instructed to evacuate the sac as often as every hour, and to remove the secretion from the conjunctival sac. If there is much swelling of and secretion from the Schneiderian membrane, I remove the secretion covering it, by means of absorbent cotton wrapped around a dentist's cotton holder, and then apply a one or two per cent. solution of nitrate of silver to the swollen membrane by means of a large camel's hair pencil once a day. I never use injections into the nose in infants, having seen more than one case in which, even in careful hands, they were followed by purulent inflammation of the middle ear. If the disease does not get well under this simple treatment, in the course of three or four weeks, I use Bowman's probes and injections of astringents in the same manner as in adults."

Dr. E. DYER, of Pittsburgh, Pa., reports a *Case of Sarcoma of the Conjunctiva.* In a healthy child, æt. 6, there was a large tumour of the conjunctiva, commencing a little to the inside of the median line of the cornea and involving the whole conjunctiva of the ball to the outer canthus. An operation had been performed on the eye, and the present mass was the growth of only one month. The entire contents of the orbit were enucleated, and the cavity thoroughly cauterized with solid nitrate of silver. The tumor was as large as an English walnut, and proved to be a spindle-celled sarcoma. The growth commenced again in less than a week and grew rapidly to an enormous size, and another tumour formed near the angle of the jaw. The skin of the upper lid burst, and violent hemorrrhages followed. The child died six months after Dr. Dyer first saw her.

In a paper on *Extirpation in Panophthalmitis*, Dr. G. C. HARLAN, of Philadelphia, discusses the propriety of the operation in such cases. Graefe advised against extirpating an eye in a state of panophthalmitis, on the ground that the danger of consequent meningitis was so great as to render the operation entirely unjustifiable. From the result of a number of cases in his own experience, and the analysis of such cases as he could find recorded, the author is inclined to agree with those who think that the danger has been overrated, and that in some cases, at least, the operation is advisable.

Dr. DAVID WEBSTER, of New York, reports a case of *Prolapse of Retina, in consequence of Hemorrhage following Iridectomy for Glaucoma.*

There was no hemorrhage at the time of the operation, but it was excited about an hour afterwards by violent vomiting, believed to be due to chloroform. A membranous mass protruded from the wound and hung down over the cornea; it was removed by the scissors, and was found, on microscopical examination, to consist of retina.

Dr. W. F. NORRIS, of Philadelphia, exhibited *Water-colour Drawings of some of the rare forms of Diseases of the Eye*, representing: I. Vascular new Growths in the Vitreous; II. Recurrent Papilloma of the Corneoscleral Junction; III. Sarcoma of the Iris; IV. Gummata of the Iris and Ciliary Body; and, V. Xerosis of Conjunctiva and Cornea, following Gelatinous Trachoma.

Dr. H. D. NOYES, of New York, gives an interesting account of a *Paresis of Inferior Oblique Muscle* occurring in his own case. He was thrown violently from a horse, and received an injury of the right malar bone. From the symptoms noted,

> "It was plain that the malar bone had been forced backward and outward, so as to be loosened from its attachment to the neighbouring bones, and that a line of fracture had gone through the infraorbital foramen and the place of origin of the inferior oblique muscle."

Dr. H. KNAPP, of New York, reports a case of *Tumour of the Optic Nerve*, and one of *Sarcoma of the Choroid, removed at an early Stage.* An attempt was made to extirpate the former without removing the ball, but was only partially successful; "the distal end at the operation was as thick as its centre, leaving no doubt that the tumour had only partially been removed." Exophthalmus, with sloughing of the cornea from exposure, and, finally, phthisis bulbi followed. Subsequent symptoms indicated that the growth, which proved to be a myxomatous glioma, was invading the cranial cavity.

In a paper on *The Diffusion Circles of Ametropia*, Dr. A. G. HEYL, of Philadelphia, proposes to ascertain if any difference worthy of note obtains between the diffusion circles as they actually exist in the cases which present themselves to us in the routine of practice, and in the typical hypermetropia or myopia which may be made to exist in the diagrammatic eye. He concludes that, while in the diagrammatic eye the diameters of the circles of diffusion are in direct proportion to the degree of ametropia, this is not the case with the eyes met with in practice. Circles of diffusion of different sizes may be found in connection with the same grades of hypermetropia, on account of variations in the corneal curve, the size of the pupil, and the position and focal distance of the crystalline lens. Dr. H. thinks that this is one reason why some patients are so much more annoyed than others by low degrees of hypermetropia. He also thinks that a difference in the circles of diffusion may determine which eye shall squint where both have the same degree of hypermetropia.

Dr. H. D. NOYES, of New York, has collated *Statistics of Extractions of Cataract by the Flap Operation and by von Graefe's Method*, including 11,000 cases of each, and finds the percentage of loss to be 16.91 in the former and 6.52 in the latter.

Dr. J. F. NOYES, of Detroit, reports *A Case of Intra-orbital Tumour of rapid growth, which resulted in Death.* The patient was a healthy looking boy, æt. 7, and the disease commenced with an injury of the eye by a foot-ball. The protruding, inflamed, and painful eye was enucleated a few weeks after the accident, but no further operative proceeding was permitted. The growth in the orbit increased rapidly, and death ensued four months after the injury. The tumour weighed one and three-quarters pounds, and proved to be a round-celled sarcoma.

A case of *Foreign Body in the Posterior Pole of the Lens—purulent Cyclitis*, is reported by Dr. THOS. R. POOLEY, of New York. On first examination, a small foreign body was seen in the posterior pole of the lens, but was concealed as the lens became opaque. About two months after the accident, cyclitis set in, necessitating enucleation of the ball, and it was found that the foreign body, a chip of iron, had passed through the lens and fallen upon the ciliary body, where it was lodged in a small abscess. G. C. H.

ART. XXXII.—*Die Lungensyphilis und ihr Verhältniss zur Lungenschwindsucht.* Von Dr. JOH. SCHNITZLER, K. K. A. O., Professor an der Wiener Universität, und Vorstand der Abtheilung für Hals- und Brustkranke an der allg. Poliklinik. 8vo. pp. 60. Wien: Urban & Schwarzenberg, 1880.

Pulmonary Syphilis, and its Relation to Pulmonary Consumption. By Dr. JOHN SCHNITZLER, Professor in the University of Vienna.

PROF. SCHNITZLER has long been favourably known in this country by his contributions to the therapeutics of diseases of the throat and chest; and the present clinical contribution from his pen sustains his well-deserved reputation as an astute and accurate observer. He has watched the evolution of a number of typical cases of pulmonary syphilis which have been under observation during a series of years. Several of these cases are narrated in detail, with illustration of the laryngoscopic appearances in their worst phases, and subsequent to successful specific treatment. He takes the ground—and, in our estimation, upon efficient data—that positive diagnosis of pulmonary syphilis requires confirmative evidence of syphilitic ulceration in the larynx. Impressed with the belief that the lungs are liable to syphilitic disease much more frequently than has heretofore been suspected, he is careful to indicate the special phenomena which differentiate pulmonary syphilis from pulmonary phthisis in tainted subjects, for which it is frequently mistaken.

Two forms of the disease are recognized: diffuse infiltration, and circumscribed gummata.

After the narration of a few observations of his own, the author gives a short, but sufficient account of the previous literature of his theme; then discusses its pathological anatomy, its etiology, pathology, symptomatology, diagnosis, and treatment; and closes with a summary of the conclusions derived from his observations and researches. As this summary is concise, and fairly represents the points discussed in detail, we present a free translation of it as representing the author's views better than any running commentary of our own:—

"1. Pulmonary syphilis occurs much more frequently than has been hitherto supposed. It is self-evidently always a sequel of general infection, and appears most frequently at a late and far advanced stage of syphilis, although it may become developed at an earlier, the so-called second, stage. It is never, however, the first and only evidence of constitutional syphilis; but always makes its appearance after other organs (skin, mucous membrane, bones, liver, testes, brain) have become attacked.